STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155237	A. BUILDING 00 B. WING	08/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY VILLAGE NURSING HOME	3518 S SHELBY ST INDIANAPOLIS, IN46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00094512. Complaint IN00094512 - Substantiated. Federal/state deficiencies related to the allegations are cited at F224 and F226. Survey dates: August 11, 12, 15, 16, & 17, 2011. Facility number: 000142 Provider number: 155237 AIM number: 100266940 Survey team: Joyce Hofmann, RN Census bed type: SNF/NF: 89 Total: 89 Census payor type: Medicare: 16 Medicaid: 65 Other: 8 Total: 89 Sample: 5 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the Plan of Correction be considered the Letter of Credible Allegation with revisit on or after 09/13/2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0224 SS=E	Quality review 8/24/11 by Suzanne Williams, RN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to ensure residents on the Memory Care unit were free of resident to resident abuse [by Residents #A and #C] for 3 of 5 residents reviewed for resident to resident altercations of abuse in a sample of 5. [Resident #B, #D, and #E] Findings include: 1). Resident #B's closed clinical record was reviewed on 08/11/11 at 12 p.m. and indicated the resident was admitted to the facility on 04/09/11 and re-admitted on 06/21/11 and 07/18/11 and had diagnoses which included, but were not limited to, bipolar disorder, cerebrovascular accident, delirium, dementia with behavioral disturbance, anxiety, and history of alcohol abuse. Resident #B was involved in 3 incident reports dated 07/02/11, 07/13/11, and 07/17/11. These incidents involved 2 different male residents - Resident #A and Resident #C. All 3 were allegations of abuse.	F0224	F224 483.13(c) Prohibit mistreatment/neglect/misappropriatn The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #B no longer resides at this facility. · Resident #D was reassessed for triggers and interventions for intrusive wandering and aggressive behaviors. Care plan was reviewed and updated. · Resident #E was reassessed for triggers and interventions for aggressive behaviors and remains on 1:1 supervision. Care plan was reviewed and updated. **How will you identify other**	09/12/2011

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	a. On 07/02/11 at 6:46 p.m. Resident #B yelled that Resident #A entered her room and was picking up things off her bed. When Resident #B tried to stop Resident #A, Resident #B indicated Resident #A slapped her in the face. Resident #B had no signs of injury. Both residents were assessed and Resident #A was removed from the situation and placed on constant supervision. MDs and families were notified and Resident #A was sent to the emergency room for evaluation. Resident #A returned to the facility on an antibiotic for an UTI [Urinary Tract Infection] and the facility psychologist was to follow. Staff met with Resident #B and her husband who had no concerns. b. On 07/13/11 at 7:15 p.m., Resident #B reported Resident #C entered her room, cornered her and slapped her. Resident #C became agitated and verbally and sexually inappropriate and physically aggressive. Resident #C entered Resident #B's room and removed his clothing down to his underwear. Resident #B became upset about Resident #C being in her room and tried several attempts to enter her room with Resident #C in there. Resident #B managed to run into her room and get her purse and came out pointing to her chest and told the nurse		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents on the Memory Care unit have the potential to be affected and are free of resident-to-resident abuse. Residents on Memory Care unit were assessed for intrusive wandering and aggressive behaviors. Care plans and CNA assignment sheets were reviewed and updated. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Memory Care employees were inserviced 07/29/2011 by Memory Care Facilitator on *Alzheimer's agitation, anger and aggression.* · Two stop signs are kept on Memory Care for immediate intervention. · Employees were inserviced on 08/15/2011 by Dr. Pederson on *Coping with the Problem Patient*. · Intrusive or aggressive behaviors are reported to the Memory Care Facilitator as soon as reasonably possible. Resident's with new or exacerbated behaviors have	

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	that Resident #C poked her in the chest. Resident #B was assessed and had no signs of injury and when re-interviewed after the incident stated she remains comfortable residing on the unit. Resident #B later told the nurse that she had called her husband and told him that a naked man came into her room while she was asleep and he sat on her bed, bent her over the bed, slapped her in the face and pushed her against the wall. This allegation was unsubstantiated per video and staff interview. c. On 07/17/11 at 7 p.m., Resident #B yelled that Resident #A entered her room. Nurse immediately responded. Resident #B said when she tried to stop Resident #A, he grabbed her by the wrist, pushed her and then slapped her after she told him that it was not his room. Resident #B sustained a 2 centimeter [cm.] superficial scratch on her wrist. Resident #B was assessed, offered a room on another unit where others would not wander into her room. Resident #B refused to be moved. An alarm and stop sign were placed on Resident #B's door and Resident #B was placed on 15 minute checks to relieve her concern with others wandering in her room. Resident #A was assessed, removed from the situation and placed on constant supervision. MDs,		behavioral triggers and interventions reviewed by the Interdisciplinary Team (IDT) no later than the business day following the new or exacerbated behaviors. · Admission team reviewed *Move-in & Admission Criteria* for Memory Care on 07/29/2011. · IDT reviewed the policy and procedure on *Abuse Prohibition, Reporting, and Investigation* policy and procedure on 08/30/2011. · Employees were inserviced by Director of Nursing by 09/09/2011 on the policy and procedure on *Abuse Prohibition, Reporting and Investigation* policy and procedure. · Employees are inserviced on abuse during orientation and periodically during ongoing inservice education as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Qualified Designee is responsible for the completion of the *Abuse Prohibition (Resident-to-Resident Altercations)* audit tool 100% of	

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	families, and personnel were notified. Resident #A was sent to the emergency room for evaluation and was placed on 15 minute checks upon his return. 2). Resident #D's clinical record was reviewed on 08/15/11 at 2:20 p.m. and indicated the resident was admitted to the facility on 05/13/11 and re-admitted on 07/23/11 and had diagnoses which included, but were not limited to, Alzheimer's Disease, psychotic disorder, and anxiety. Resident #D's Resident Progress Notes dated 07/09/11 indicated, "Resident wander into other resident room the other resident yelled out saying leave my room, leave my room et [and] get [sic] her upper body up from her bed, clach [sic] fist trying to hit him. He bend [sic]over to fight back and she hit him in the face and they got into fight. Resident choked her leaving mard [sic] on her left and right neck. Staff separated them forcefully and remove [sic] him from room. Unit faciltator [sic], MD and Family notified. And resident send out to [name of hospital] hospital for evaluation." 3). Resident #E's clinical record was reviewed on 08/15/11 at 3:30 p.m. and indicated the resident was admitted to the facility on 04/09/11 and re-admitted on		resident-to-resident altercation for four weeks, then up to ten altercations quarterly thereafter for two cycles with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold is not achieved an action plan will be developed to ensure compliance.	

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	07/09/11 and had diagnoses which included, but were not limited to, Dementia, Schizophrenia, Anoxic Encephalopathy, and Intracranial Hemorrhage. Resident #E's Resident Progress Notes dated 07/09/11 indicated, "Other resident wanders into her room and resident yelled out to leave her room multiple times and get [sic] her upper body up from her bed fisting out to him then he bend [sic] over to fight back and he [sic] hit him in his face. They got into fighting and the other chocked [sic] her leaving mark on her left and right neck. Staff separated them forcefully and removed the other resident to his room. Unit facilitator, MD and Family notified and resident send [sic] out to [name of hospital] Hospital for evaluation." The Facility Incident Reporting Form dated 07/09/2011 indicated the nurse was in the room when the female resident yelled and the nurse called for assistance, and separated the residents. The follow-up report indicated Resident #D was legally blind and has a history of wandering. The report indicated the female resident recently returned on 07/08/11 from a hospital stay to adjust medications. The report indicated Resident #D had no visible signs of			

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	injuries, but the female resident had a bleeding lip and marks on her neck. The report indicated the Immediate Action Taken was both residents were assessed, families were notified, and both residents were sent to the emergency room for evaluation. The facility's preventative measures taken were both residents placed on 15 minute checks upon return from the hospital; the facility psychologist was to evaluate both residents on 07/11/11; both residents had their psychotic medications adjusted by the psychologist; and care plans were reviewed and updated. The facility's Abuse Prohibition, Reporting, and Investigation Policy and Procedure, dated 02/2010, was reviewed on 08/11/11 at 12 p.m. and indicated, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds." The policy's Definition of Abuse indicated, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish.			

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	This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish." "Physical Abuse - includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse - defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and/or speaking to them in harsh voice tones. Sexual Abuse - includes but is not limited to, sexual harassment, sexual coercion, or sexual assault. Mental Abuse - includes, but is not limited to, humiliation, harassment,			

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	threats of punishment, or deprivation. Neglect - failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents. Neglect occurs when a facility fails to provide necessary care for resident, such as situations in which residents are being left to lie in urine or feces...." The policy for resident to resident abuse dated 02/2010 indicated, "Policy: It is the policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident(s) is maintained is [sic] abuse is identified or suspected. Procedure: If resident-to-resident abuse is identified, or there is suspicion of resident-to-resident abuse, the following guidelines will be followed: 1. Any individual who witnesses resident-to-resident abuse will immediately separate the residents involved. 2. The individual who witnessed the abuse will report the situation immediately to his/her supervisor.			

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	3. The staff member in charge will initiate the investigation immediately. 4. Staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained. 5. The Executive Director and/or Director of Nursing will be notified of the report and the initiation of the investigation. 6. The charge nurse will assess both residents involved to determine if physical injuries have occurred. a. Residents will be questioned (if alert and competent) about the nature of the incident b. Statements will be taken from any one witnessing the incident. 7. The attending physician will be notified and any orders will be noted and initiated. The affected resident (s) will be transferred for further evaluation, if indicated. 8. The family of the resident (s) and/or responsible party will be notified. 9. Follow up assessments will			

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	completed/documented every shift until the resident (s) is stable, and resident (s) safety is maintained. 10. The Behavior Management team will assess the situation and make recommendations for further interventions. 11. In the event a behavior management plan is unsuccessful, or if the team feels that the inappropriate behavior poses a risk to other residents, the facility reserves the right to discharge the resident. 12. It is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of abuse, within 24 hours to the Indiana State Department of Health. 13. The Administrator/Director of Nursing will report the final results of the investigation to the Indiana State Department of Health within five working days. (Refer to the Unusual Occurrence guidelines)." Review of the Resident Rights dated 10/97 indicated, "... The resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion...."			

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	This federal deficiency is related to Complaint IN00094512. 3.1-27(a)(3) 3.1-28(a)			
F0226 SS=E	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, interview, and record review, the facility failed to implement their policy and procedures for prevention of abuse for 4 of 5 residents reviewed for resident to resident altercations of abuse in a sample of 5 and potentially could have affected 18 residents who resided on the Memory Care unit. [Resident #A, #B, #D, and #E] Findings include: On 08/12/11 at 3:23 p.m., the Memory Care unit facilitator, QMA #1, provided the policy and procedure entitled, "Move-In & Admission Criteria" with revision date of 6/09 which indicated, "Policy It is the practice of this provider to accurately assess residents prior to move in a variety of settings. The assessment will include physical, medical, cognitive, social, and psychiatric evaluations." The Procedure indicated the	F0226	F226 483.13(c) Develop/implment The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident #A no longer resides at this facility. · Resident #B no longer resides at this facility. · Resident #D was reassessed for triggers and interventions for intrusive wandering and aggressive behaviors. Care plan was reviewed and updated. · Resident #E was	09/12/2011

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	following: * Memory Care Facilitator/Designee shall assess resident in current living situation and will complete the following: * Conversation with potential resident to assess cognitive level * Assessment of ambulation and physical functioning * Assessment of behavioral status * Shall complete an American Senior Communities Resident Assessment form * Shall complete an MMSE within 7 days of admission to gain an objective level of functioning to further support team placement decision * Responsible family member will be given Personal History form to be completed as thoroughly as possible. This form should be completed before move in if possible * Memory Care Facilitator/Designee shall meet with facility team to discuss results of pre-admission interview and resident assessment * Resident may be deemed inappropriate for Alzheimer's Care for the following reasons:		reassessed for triggers and interventions for aggressive behaviors and remains on 1:1 supervision. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents on the Memory Care unit have the potential to be affected and are free of resident-to-resident abuse. Residents on Memory Care unit were assessed for intrusive wandering and aggressive behaviors. Care plans and CNA assignment sheets were reviewed and updated. Residents on Memory Care unit were assessed to ensure they meet unit criteria. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Memory Care employees were inserviced 07/29/2011 by Memory Care Facilitator on *Alzheimer's agitation, anger and aggression.* · Two stop signs are kept on Memory Care for immediate intervention. · Sexual predator	

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	* Lack of definitive dementia diagnosis * History of physical combativeness within the last 30 days (unless clearly defined, manageable antecedent has been identified and can be avoided in Cottage) * Unmanageable incontinence or extensive fecal smearing * Behavior that is excessively destructive to surrounding environment * Active psychiatric involvement including depression (chronic or bipolar), schizophrenia, delusional disorder, severe anxiety or panic disorder, Lewy Body Dementia * Unmanageable, inappropriate, or aggressive sexual behavior * Care that is too extensive for proposed setting per ASC Cottage Discharge Policy * Executive Director/Designee shall make final decision regarding acceptance/denial utilizing the Alzheimer's Disease handout adopted from Dr. Reisberg's Global Deterioration		background checks are run for all potential Memory Care residents by the admissions coordinator. · *Getting to Know You* form will be completed on all new Memory Care residents by the admissions coordinator or Memory Care Facilitator. · A buddy will be assigned for the first shift of each new Memory Care resident. · Employees were inserviced on 08/15/2011 by Dr. Pederson on *Coping with the Problem Patient*. · Intrusive or aggressive behaviors are reported to the Memory Care Facilitator as soon as reasonably possible. Resident's with new or exacerbated behaviors have behavioral triggers and interventions reviewed by the Interdisciplinary Team (IDT) no later than the business day following the new or exacerbated behaviors. · Memory care employees were inserviced by the Memory Care Facilitator by 09/09/2011 on behavior management program, 1:1 supervision and 15 minute · Admission team reviewed *Move-in & Admission Criteria* for Memory Care on 07/29/2011. · IDT reviewed the policy	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Scale." Interview with QMA #1 on 08/12/11 at 3:32 p.m. indicated the facility had also implemented criminal background checks on new admissions. 1). Resident #A's closed clinical record was reviewed on 08/12/11 at 9:35 a.m. and indicated an original admission date of 06/30/11 and a re-admission date of 07/22/11. Resident #A's diagnoses included, but were not limited to, Alzheimer's Disease, end stage dementia, dementia with behavioral disturbances, legally blind, macular degeneration, urinary tract infection, upper respiratory infection, c-diff [Clostridium Difficile], hearing loss, chronic ischemic heart disease, coronary artery disease, and osteoarthritis. Resident #A's facility pre-admission assessment dated 06/23/11 indicated the resident lived at home with wife and needed long term care as the wife was unable to care for him any longer. The assessment indicated, "little hx [history] on patient." The assessment indicated the resident's mental status varied over the course of the day. Resident #A's Aging & In-Home Solutions Pre-Admission Screening		and procedure on *Abuse Prohibition, Reporting, and Investigation* policy and procedure on 08/30/2011. · Employees were inserviced by Director of Nursing by 09/09/2011 on the policy and procedure on *Abuse Prohibition, Reporting and Investigation* policy and procedure. · Employees are inserviced on abuse during orientation and periodically during ongoing inservice education as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DNS/Qualified Designee is responsible for the completion of the *Abuse Prohibition (Resident-to-Resident Altercations)* audit tool 100% of resident-to-resident altercation for four weeks, then up to ten altercations quarterly thereafter for two cycles with results reported to the Continuous Quality Improvement (CQI) committee overseen by the executive director. If threshold is not achieved an action plan will be developed to ensure compliance.	

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	155237	A. BUILDING 00 B. WING	08/17/2011

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	Program, with no date, indicated the reason for admission as, "Res. [Resident] is wandering. Got out of the house." Resident #A's closed clinical record indicated the resident was admitted from home on an emergency basis, requires a secured unit, and wanders. Resident Progress Notes dated 07/02/11 at 4:25 p.m. indicated the resident was wandering around in and out of other residents' rooms and Resident #B alleged Resident #A slapped her in her face after she told him not to take her things. Resident Progress Notes dated 07/10/11 at 4:07 a.m. indicated Resident #A was sexually inappropriate. Resident Progress Notes dated 07/17/11 at 7 p.m. indicated Resident #A wondered into Resident #B's room and grabbed Resident #A by the wrist and twisted it then slapped the resident. Resident Progress Notes dated 07/25/11 at 10:14 a.m. indicated Resident #A came out into the hallway, pulled penis out of pull up and voided in the hallway, then hacked and spit on the floor. The notes also indicated on 07/23/11 in the middle of the night, Resident #A went into the main shower room and voided bowel and		Memory Care Facilitator/Qualified Designee is re is responsible for the completion of the *psychoactive Medication/Behavior Management* audit tool for 100% of residents with new or exacerbating behaviors for four weeks, then up to 10 new or exacerbating behaviors quarterly thereafter for two cycles with results reported to the CQI committee overseen by the executive director. If threshold is not achieved an action plan will be developed to ensure compliance.	

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	urine on the floor. Resident #A's Psychological Evaluation dated 07/11/11 indicated Resident #A had "recent episode of physical aggression toward another resident. Patient with history of inappropriate sexual behavior toward his wife while still living at home. Patient currently undergoing antibiotic treatment for UTI [Urinary Tract Infection] as well as URI [Upper Respiratory Infection]...." 2). Resident #C closed clinical record was reviewed on 08/12/11 at 10:40 a.m. and indicated the resident was admitted on 07/13/11 with diagnoses which included, but were not limited to, Alzheimer's Disease, senile dementia, and sexual aggression. The closed clinical record and hospital records dated 07/04/11 indicated the resident was hospitalized prior to admission to the facility for altered mental status and dementia. The resident had been brought to the emergency department by police for immediate detention as he was found to be wandering the streets and to be aggressive. The hospital record indicated Resident #C lived with his wife who was unable to care for him anymore as he had been becoming more aggressive. The			

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	resident received Haldol (antipsychotic) in the emergency department and became less belligerent. Hospital records indicated as evening progressed the resident appeared more focused on his wife verbalizing belief of her infidelity, and her "spending all my money." The hospital records notes dated 07/11/11 indicated Resident #C displayed agitation as associated with phone call to wife, during which he was overheard making threatening statement, followed by abruptly hanging up phone. The notes indicated Resident #C received scheduled medication as well as prn antianxiety/antipsychotic medications with limited results. Resident #C's Resident Assessment dated 07/13/11 indicated Current Problems/Reason for Placement as "increased signs and symptoms of Dementia. Wife is #1 care provider having increased difficulty handling him @ [at] home. indep. [Independent]. Was (+) Paranoid thoughts, impulsiveness, increased sexual drive. Pt. [Patient] admitted. Increased Depo shot dossage [sic] & med changes made. Pt. in need of secured unit c [with] Rehab transitioning into Long Term Memory Care." The Comprehensive-Thinking/Awareness part of the assessment indicated the			

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	resident was easily distracted, had periods of lethargy, had episodes of disorganized speech, his mental function varied over the course of the day, had periods of restlessness, and periods of altered perception of surrounding. The assessment indicated the resident was alert and oriented to person only and was confused. Comments indicated the resident was obsessed with wife, having sex frequently with her, impulsive, tried to drive, won't listen to wife, and following commands of staff. Resident Progress Notes dated 07/13/11 at 10:12 p.m. indicated, "Resident aggressive [sic] towards staff and peers. Verbal agression [sic], intrusive wandering, pulling covers down from unoccupied resident's bed, hiting [sic], kicking and slaming [sic] doors, unacceptable sexual behavior toward staff and unacceptable sexual comments towards residents, grabbing others, making negative statements [sic] and unacceptable social behaviors. Behavior sheet filled out on each incident. Each and every resident was on the hall way after resident's behavior and he was running around each room and hall way with underware [sic] on calling for wife and asking female residents to go to bed with him...."			

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	Interdisciplinary Team notes dated 07/14/11 indicated, "Behavior follow-up: Following resident's aggressive behavior from last evening. Reviewed precipitating factors for behavior. Resident had resided on unit less than ten hours. Wife had been into visit with resident from 2p-4p. Resident paced on unit, but showed no physical aggression prior to supper. Demonstrated increased restlessness by pacing in hallways, wandering into and out of resident rooms looking and calling for his wife. Exited dining room several times to patio and returned with staff direction. Residents normal bedtime was following the evening news which is when his behaviors escalated. Unable to successfully redirect resident due to his hypervigilance in attempting to find his wife leading him to go into an empty room, disrobe to his underware [sic], and sit on a bed. He continued to occupy the resident's room standing in the doorway. He then proceeded down the hallway in his underware [sic] clenching his fists banging on closed doors and trying to enter. Staff members stayed with resident at a safe distance attempting to calm and then protect until MD could be notified for intervention. Resident calmed slightly when transport personnel and police arrived on unit. Wife was present at time of ambulance arrival. Resident climbed			

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	onto gurney with direction without physical coercion. Wife notified of immediate discharge due to safety of resident and other...hospital DC planner called to reconfirm that while resident was at [hospital], he never demonstrated any of the behaviors he displayed at the facility." The Behavior Log for 8:15 p..m. indicated Resident #C went into Resident #B's room and threw her belongings around, and hit Resident #B when she asked him to get out of her room. 3). Resident #D was observed on 08/11/11 at 10:15 a.m. sitting in the dining area next to a table watching television. The resident appeared relaxed slumped down in his chair with hands folded. During interview with QMA #1 at this time, the QMA indicated the resident was ambulatory, had poor vision, wants his wife, and family visit every evening. Resident #D's clinical record was reviewed on 08/15/11 at 2:20 p.m. and indicated the resident was admitted to the facility on 05/13/11 and re-admitted on 07/23/11 and had diagnoses which included, but were not limited to, Alzheimer's Disease, psychotic disorder, and anxiety.			

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	Resident #D's Resident Assessment dated 05/08/11 indicated the resident had been aggressive at home with wife, had severe dementia, and found to have an UTI, paranoid ideations at home, and had a gun and knife which the son took gun from home. The assessment indicated the resident had periods of lethargy, was very sleepy, laying down, barely opens eyes, slurred speech, and his mental function varied over the course of the day. The hospital discharge summary dated 05/13/11 indicated the resident had increased confusion leading to irritability and paranoia at home that lead to assault of his wife. Resident reported that he had a knife and a gun out because he was practicing using it. On admission he denied any suicidal or homicidal ideations and auditory or visual hallucinations. Per the social worker, the resident had been having increasingly bizarre behavior over the past few weeks to months where he had become more paranoid about intruders coming into his home and if his wife was cheating on him. On the day of admission, he put a kitchen knife in his pocket and told his wife he would kill her the first chance he got and assaulted her by hitting her on the top of her head. During his hospital course the resident was found to have an UTI and would			

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	become increasingly agitated in the evenings and night as he was given multiple doses of ativan and one dose of haldol after which the haldol was discontinued due to tremors. Throughout the resident's hospital stay, the resident continued to have a sundowning effect that would occur every evening and he would get agitated and confused. One on one attention from nursing was needed. However, on discharge this agitation was greatly decreased and ativan was rarely needed to be given. Resident #D's psych progress note dated 07/12/11 indicated the resident was seen for follow-up due to incident of physical aggression toward another resident. The resident wandered into a female resident's room. The female resident, Resident #E, hit Resident #D in the face and he proceeded to attempt to choke her, leaving marks on her neck. Resident #D was sent out to evaluation and returned to the facility the same day. The resident had multiple instances of wandering into other resident's room, and an incident of verbal aggression toward another resident this morning. Resident Progress Notes dated 07/09/11 at 8 p.m. indicated, "Resident wander [sic] into other resident room the other resident yelled out saying leave my room, leave			

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	my room et [and] get [sic] her upper body up from her bed, clach [sic] fist trying to hit him. He bed over to fight back and she hit him in the face and they got into fight. Resident choked her leaving mard [sic] on her left and right neck. Staff separated them forcefully and remove [sic] him from room...." 4). Resident #E was observed on 08/11/11 at 10:15 a.m. sitting at the dining room table. The resident was calm, dressed in pink and was dressed appropriately. Per interview with the QMA #1 at this time, the resident was ambulatory and had been sent out for medication adjustments and had returned on 07/08/11. Resident #E's clinical record was reviewed on 08/15/11 at 3:30 p.m. and indicated the resident was admitted to the facility on 04/09/11 and re-admitted on 07/09/11 and had diagnoses which included, but were not limited to, Dementia, Schizophrenia, Intracranial Hemorrhage, and Anoxic Encephalopathy. Resident #E's pre-admission screening, with no date, indicated as reason for admission, "Resident wandering, found by police & brought back to dtr's [daughter's] apartment. Res. unable to live alone, dtr. unable to provide 24/7 care."			

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	Resident #E's psych progress notes dated 06/20/11 indicated the resident was seen for follow up secondary to continued physical and verbal aggression. The resident had a slight decrease in aggressive behavior after last increase in antipsychotic medication, but aggressive and combative behaviors had again escalated. Resident with reported fist clenching, cursing, and verbal and physical threats. Resident presents with frequent poorly constructed delusions; such as believing there is an upper level to the facility and demanding to 'go upstairs.' Recommendations included, but were not limited to, sending the resident out for inpatient psychiatric facility for stabilization of psychotic symptoms and aggression. The resident was sent out on 06/21/11 - 07/08/11 and upon return was given a 30 day discharge notice. Resident Progress Notes dated 06/03/11 indicated Resident #E got into a fight with her roommate after arguing and roommate hit her first and Resident #E hit her back on face causing a nose bleed to occur. Resident Progress Notes dated 06/06/11 indicated Resident #E hit CNA in chest after being redirected for taking other			

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	resident's belongings. Resident Progress Notes dated 06/07/11 indicated Resident #E balled up her fist, yelling and expressing verbal aggression toward staff member when asked not to go into another resident's room. Resident Progress Notes dated 06/09/11 indicated, "behaviors, agitated, angry because her wanted to see her brother, redirected, raised fist to staff, remains on 15 min [minute] checks, in and out of room, walking in hall with clothes off, redirected, became angry...." Resident Progress Notes dated 07/09/11 indicated, "Other resident [Resident #D] wanders into her room and resident yelled out to leave her room multiple times and get her upper body up from her bed fisting out to him then he bend over to fight back and she hit him in his face. They got into fighting and the other resident chocked her leaving mark on her left and right neck. Staff separated them forcefully and removed the other resident to his room...." These four residents were admitted to the facility, and the facility failed to follow their policy for admission criteria which resulted in 5 residents involved in abuse altercations.			

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	The facility's Abuse Prohibition, Reporting, and Investigation Policy and Procedure, which had no date, was reviewed on 08/11/11 at 12 p.m. and indicated, "It is the policy of American Senior Communities to protect residents from abuse including physical abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or funds." The policy's Definition of Abuse indicated, "Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or pain, or mental anguish. This includes deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain, or mental anguish." "Physical Abuse - includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse - defined as the use of oral, written, or gestured language that willfully includes disparaging and			

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	derogatory terms to resident or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and/or speaking to them in harsh voice tones. Sexual Abuse - includes but is not limited to, sexual harassment, sexual coercion, or sexual assault. Mental Abuse - includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation. Neglect - failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect occurs when facility staff fails to monitor and/or supervise the delivery of resident care and services to assure that care is provided as needed by the residents. Neglect occurs when a facility fails to provide necessary care for resident, such as situations in which residents are being left to lie in urine or feces...." The policy and procedure indicated the facility "will not permit residents to be			

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	subjected to abuse by anyone, including employees, other residents, consultants, volunteers, staff or personnel of other agencies serving the resident, family members, legal guardians, sponsors, friends, or other individuals." The policy indicated employees screening is done on all potential employees to assure that the facility does not employ individuals who have been found guilty of crimes against a dependent population, who do not have current licensure or certification clear of findings concerning abuse, neglect, and mistreatment of residents, corporal punishment, involuntary seclusion, or misappropriation of resident property, and who do not have a clear criminal background check. The policy indicated employees receive instruction/training on abuse during orientation and periodically during ongoing inservice education which includes, what constitutes abuse, to whom to report abuse and when, how to protect residents from immediate danger, intervention techniques to be used with residents exhibiting aggressive or catastrophic reactions, his/her responsibility upon witnessing abuse, and his/her role in an investigation. Residents and their families are educated as to whom and how to report allegations,			

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	incidents, and/or complaints without fear of retribution. Residents and families are also educated on the process of receiving feedback/resolution regarding concerns that have been expressed. This education occurs at admission, and during the resident and family council meetings. Supervisory personnel are responsible to monitor, through observation and counseling as needed, staff/resident interactions, and the provision of care and services to the resident. The policy for resident to resident abuse dated 02/2010 indicated, "Policy: It is the policy of American Senior Communities to assure appropriate interventions are in place and followed to assure safety of the resident(s) is maintained is [sic] abuse is identified or suspected. Procedure: If resident-to-resident abuse is identified, or there is suspicion of resident-to-resident abuse, the following guidelines will be followed: 1. Any individual who witnesses resident-to-resident abuse will immediately separate the residents involved. 2. The individual who witnessed the abuse will report the situation immediately to his/her supervisor. 3. The staff member in charge will			

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	155237	A. BUILDING 00 B. WING	08/17/2011

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	initiate the investigation immediately. 4. Staff member (s) will maintain the resident initiating the abuse under direct supervision until the initial investigation is complete and resident safety is maintained. 5. The Executive Director and/or Director of Nursing will be notified of the report and the initiation of the investigation. 6. The charge nurse will assess both residents involved to determine if physical injuries have occurred. a. Residents will be questioned (if alert and competent) about the nature of the incident b. Statements will be taken from any one witnessing the incident. 7. The attending physician will be notified and any orders will be noted and initiated. The affected resident (s) will be transferred for further evaluation, if indicated. 8. The family of the resident (s) and/or responsible party will be notified. 9. Follow up assessments will completed/documented every shift until the resident (s) is stable, and resident (s)			

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	safety is maintained. 10. The Behavior Management team will assess the situation and make recommendations for further interventions. 11. In the event a behavior management plan is unsuccessful, or if the team feels that the inappropriate behavior poses a risk to other residents, the facility reserves the right to discharge the resident. 12. It is the responsibility of the Administrator/Director of Nursing to report the abuse, or allegations of abuse, within 24 hours to the Indiana State Department of Health. 13. The Administrator/Director of Nursing will report the final results of the investigation to the Indiana State Department of Health within five working days. (Refer to the Unusual Occurrence guidelines)." This federal deficiency is related to Complaint IN00094512. 3.1-28(a)			